

AMENDED IN ASSEMBLY JUNE 28, 2011

AMENDED IN SENATE MAY 31, 2011

AMENDED IN SENATE MAY 9, 2011

AMENDED IN SENATE APRIL 25, 2011

AMENDED IN SENATE APRIL 5, 2011

## **SENATE BILL**

**No. 51**

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### **Introduced by Senator Alquist**

December 15, 2010

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An act to add Sections 1367.001 and 1367.003 to the Health and Safety Code, and to add Sections 10112.1 and 10112.25 to the Insurance Code, relating to health care coverage.

#### LEGISLATIVE COUNSEL'S DIGEST

SB 51, as amended, Alquist. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law prohibits a health care service plan from expending for administrative costs, as defined, an excessive amount of the payments the plan receives for providing health care services to its subscribers and enrollees.

Existing law provides for the regulation of health insurers by the Department of Insurance. The Insurance Commissioner is required to withdraw approval of an individual or mass-marketed health insurance policy if the commissioner finds that the benefits provided under the policy are unreasonable in relation to the premium charged, as specified.

The federal Patient Protection and Affordable Care Act prohibits a health insurance issuer issuing health insurance coverage from establishing lifetime limits or unreasonable annual limits on the dollar value of benefits for any participant or beneficiary, as specified. The act also requires a health insurance issuer issuing health insurance coverage to comply with minimum medical loss ratios and to provide an annual rebate to each insured if the medical loss ratio of the amount of the revenue expended by the issuer on costs to the total amount of premium revenue is less than a certain percentage, as specified.

This bill would require health care service plans and health insurers to comply with the requirements imposed under those federal provisions, as specified. The bill would authorize the Director of the Department of Managed Health Care and the Insurance Commissioner to promulgate regulations and emergency regulations to implement requirements relating to medical loss ratios, as specified.

Because a willful violation of those requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 1367.001 is added to the Health and
- 2 Safety Code, to read:
- 3 1367.001. (a) To the extent required by federal law, every
- 4 health care service plan that issues, sells, renews, or offers contracts
- 5 for health care coverage in this state shall comply with the
- 6 requirements of Section 2711 of the federal Public Health Service
- 7 Act (42 U.S.C. Sec. 300gg-11) and any rules or regulations issued
- 8 under that section, in addition to any state laws or regulations that
- 9 do not prevent the application of those requirements.
- 10 (b) *This section shall not apply to a specialized health care*
- 11 *service plan, a health care service plan offered in the Medi-Cal*
- 12 *program (Chapter 7 (commencing with Section 14000) of Part 3*

1 of Division 9 of the Welfare and Institutions Code), or a health  
2 care service plan offered in the Healthy Families Program (Part  
3 6.2 (commencing with Section 12693) of Division 2 of the  
4 Insurance Code), the California Major Risk Medical Insurance  
5 Program (Part 6.5 (commencing with Section 12700) of Division  
6 2 of the Insurance Code), or the Federal Temporary High Risk  
7 Insurance Pool (Part 6.6 (commencing with Section 12739.5) of  
8 Division 2 of the Insurance Code).

9 SEC. 2. Section 1367.003 is added to the Health and Safety  
10 Code, to read:

11 1367.003. (a) Every health care service plan that issues, sells,  
12 renews, or offers health care service plan contracts for health care  
13 coverage in this state, including a grandfathered health plan, but  
14 not including specialized health care service plan contracts, shall  
15 provide an annual rebate to each enrollee under such coverage, on  
16 a pro rata basis, if the ratio of the amount of premium revenue  
17 expended by the health care service plan on the costs for  
18 reimbursement for clinical services provided to enrollees under  
19 such coverage and for activities that improve health care quality  
20 to the total amount of premium revenue, excluding federal and  
21 state taxes and licensing or regulatory fees and after accounting  
22 for payments or receipts for risk adjustment, risk corridors, and  
23 reinsurance, is less than the following:

24 (1) With respect to a health care service plan offering coverage  
25 in the large group market, 85 percent.

26 (2) With respect to a health care service plan offering coverage  
27 in the small group market or in the individual market, 80 percent.

28 (b) Every health care service plan that issues, sells, renews, or  
29 offers health care service plan contracts for health care coverage  
30 in this state, including a grandfathered health plan, shall comply  
31 with the following minimum medical loss ratios:

32 (1) With respect to a health care service plan offering coverage  
33 in the large group market, 85 percent.

34 (2) With respect to a health care service plan offering coverage  
35 in the small group market or in the individual market, 80 percent.

36 (c) (1) The total amount of an annual rebate required under this  
37 section shall be calculated in an amount equal to the product of  
38 the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health care service plan shall provide any rebate owing to an enrollee no later than August 1 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) (1) The director may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(2) The director may also adopt emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) when it is necessary to implement the applicable provisions of this section and to address specific conflicts between state and federal law that prevent implementation of federal law and guidance pursuant to Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial adoption of the emergency regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

(e) The department shall consult with the Department of Insurance in adopting necessary regulations, and in taking any other action for the purpose of implementing this section.

(f) This section shall be implemented to the extent required by federal law and shall comply with, and not exceed, *the scope of Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under that section those sections.*

(g) *This section shall not apply to a specialized health care service plan, a health care service plan offered in the Medi-Cal*

1 *program (Chapter 7 (commencing with Section 14000) of Part 3*  
2 *of Division 9 of the Welfare and Institutions Code), or a health*  
3 *care service plan offered in the Healthy Families Program (Part*  
4 *6.2 (commencing with Section 12693) of Division 2 of the*  
5 *Insurance Code), the California Major Risk Medical Insurance*  
6 *Program (Part 6.5 (commencing with Section 12700) of Division*  
7 *2 of the Insurance Code), or the Federal Temporary High Risk*  
8 *Insurance Pool (Part 6.6 (commencing with Section 12739.5) of*  
9 *Division 2 of the Insurance Code).*

10 SEC. 3. Section 10112.1 is added to the Insurance Code, to  
11 read:

12 10112.1. (a) To the extent required by federal law, every health  
13 insurer that issues, sells, renews, or offers policies for health care  
14 coverage in this state shall comply with the requirements of Section  
15 2711 of the federal Public Health Service Act (42 U.S.C. Sec.  
16 300gg-11) and any rules or regulations issued under that section,  
17 in addition to any state laws or regulations that do not prevent the  
18 application of those requirements.

19 (b) *This section shall not apply to a specialized health insurance*  
20 *policy, a health insurance policy offered in the Medi-Cal program*  
21 *(Chapter 7 (commencing with Section 14000) of Part 3 of Division*  
22 *9 of the Welfare and Institutions Code), or a health insurance*  
23 *policy offered in the Healthy Families Program (Part 6.2*  
24 *(commencing with Section 12693)), the California Major Risk*  
25 *Medical Insurance Program (Part 6.5 (commencing with Section*  
26 *12700)), or the Federal Temporary High Risk Insurance Pool*  
27 *(Part 6.6 (commencing with Section 12739.5)).*

28 SEC. 4. Section 10112.25 is added to the Insurance Code, to  
29 read:

30 10112.25. (a) Every health insurer that issues, sells, renews,  
31 or offers health insurance policies for health care coverage in this  
32 state, including a grandfathered health plan, but not including  
33 specialized health insurance policies, shall provide an annual rebate  
34 to each insured under such coverage, on a pro rata basis, if the  
35 ratio of the amount of premium revenue expended by the health  
36 insurer on the costs for reimbursement for clinical services  
37 provided to insureds under such coverage and for activities that  
38 improve health care quality to the total amount of premium  
39 revenue, excluding federal and state taxes and licensing or  
40 regulatory fees and after accounting for payments or receipts for

1 risk adjustment, risk corridors, and reinsurance, is less than the  
2 following:

3 (1) With respect to a health insurer offering coverage in the  
4 large group market, 85 percent.

5 (2) With respect to a health insurer offering coverage in the  
6 small group market or in the individual market, 80 percent.

7 (b) Every health insurer that issues, sells, renews, or offers health  
8 insurance policies for health care coverage in this state, including  
9 a grandfathered health plan, shall comply with the following  
10 minimum medical loss ratios:

11 (1) With respect to a health insurer offering coverage in the  
12 large group market, 85 percent.

13 (2) With respect to a health insurer offering coverage in the  
14 small group market or in the individual market, 80 percent.

15 (c) (1) The total amount of an annual rebate required under this  
16 section shall be calculated in an amount equal to the product of  
17 the following:

18 (A) The amount by which the percentage described in paragraph  
19 (1) or (2) of subdivision (a) exceeds the ratio described in paragraph  
20 (1) or (2) of subdivision (a).

21 (B) The total amount of premium revenue, excluding federal  
22 and state taxes and licensing or regulatory fees and after accounting  
23 for payments or receipts for risk adjustment, risk corridors, and  
24 reinsurance.

25 (2) A health insurer shall provide any rebate owing to an insured  
26 no later than August 1 of the calendar year following the year for  
27 which the ratio described in subdivision (a) was calculated.

28 (d) (1) The commissioner may adopt regulations in accordance  
29 with the Administrative Procedure Act (Chapter 3.5 (commencing  
30 with Section 11340) of Part 1 of Division 3 of Title 2 of the  
31 Government Code) that are necessary to implement the medical  
32 loss ratio as described under Section 2718 of the federal Public  
33 Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal  
34 rules or regulations issued under that section.

35 (2) The commissioner may also adopt emergency regulations  
36 in accordance with the Administrative Procedure Act (Chapter 3.5  
37 (commencing with Section 11340) of Part 1 of Division 3 of Title  
38 2 of the Government Code) when it is necessary to implement the  
39 applicable provisions of this section and to address specific  
40 conflicts between state and federal law that prevent implementation

1 of federal law and guidance pursuant to Section 2718 of the federal  
2 Public Health Service Act (42 U.S.C. Sec. 300gg-18). The initial  
3 adoption of the emergency regulations shall be deemed to be an  
4 emergency and necessary for the immediate preservation of the  
5 public peace, health, safety, or general welfare.

6 (e) The department shall consult with the Department of  
7 Managed Health Care in adopting necessary regulations, and in  
8 taking any other action for the purpose of implementing this  
9 section.

10 (f) This section shall be implemented to the extent required by  
11 federal law and shall comply with, and not exceed, *the scope of*  
12 *Section 2791 of the federal Public Health Service Act (42 U.S.C.*  
13 *Sec. 300gg-91)* and the requirements of Section 2718 of the federal  
14 Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules  
15 or regulations issued under ~~that section~~ *those sections*.

16 (g) *This section shall not apply to a specialized health insurance*  
17 *policy, a health insurance policy offered in the Medi-Cal program*  
18 *(Chapter 7 (commencing with Section 14000) of Part 3 of Division*  
19 *9 of the Welfare and Institutions Code), or a health insurance*  
20 *policy offered in the Healthy Families Program (Part 6.2*  
21 *(commencing with Section 12693)), the California Major Risk*  
22 *Medical Insurance Program (Part 6.5 (commencing with Section*  
23 *12700)), or the Federal Temporary High Risk Insurance Pool*  
24 *(Part 6.6 (commencing with Section 12739.5)).*

25 SEC. 5. No reimbursement is required by this act pursuant to  
26 Section 6 of Article XIII B of the California Constitution because  
27 the only costs that may be incurred by a local agency or school  
28 district will be incurred because this act creates a new crime or  
29 infraction, eliminates a crime or infraction, or changes the penalty  
30 for a crime or infraction, within the meaning of Section 17556 of  
31 the Government Code, or changes the definition of a crime within  
32 the meaning of Section 6 of Article XIII B of the California  
33 Constitution.